CODE	Section	DOMAIN 3 HEALTH SERVICES DELIVERY
		AVAILABILITY AND ACCESSIBILITY

QH 01 ~~New Element~~	**The M+CO ensures that all covered services, including additional or supplemental services contracted for by or on behalf of Medicare ~~or Medicaid~~ enrollees, are available and accessible. ~~Note: The M+CO must ensure that all services are available: that is, that it has employed or contracted with appropriately qualified institutional and individual providers, and that these providers have sufficient capacity to make services available to the M+CO's enrollees.~~ CFR 422.112 (a)., QISMC requirement 3.1** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 01	Note: The M+CO must ensure that all services are available: that is, that it has employed or contracted with appropriately qualified institutional and individual providers, and that these providers have sufficient capacity to make services available to the M+CO's enrollees. **[**If the M+CO requested and HCFA approved a "continuation area per 422.54," Medicare-covered services in 422.101(a) are available in the "continuation area" to the extent required by 422.54~~(b)~~] The M+CO must also ensure accessibility: that is, enrollees must be informed about the existence of the services and the procedures for obtaining services when needed. Accessibility further requires that: services be geographically reachable, consistent with local community patterns of care; and that enrollees not experience undue waiting periods, either for obtaining an appointment or at the time of the appointment. Language and cultural barriers, as well as, barriers to those individuals with physical or mental disabilities must also be addressed. Cross Refer to Enrollee Rights, Standards 2.1.2 and 2.2.2. Review and/or Determine: ■ ~~Review~~ all HSD tables to determine numbers, types, and geographic location of the M+CO's provider network. ■ ~~Does the M+CO have~~ written arrangements to provide all Medicare covered services including additional and supplemental. ■ ~~The M+CO should have~~ information that reflects an ongoing analysis of the expected utilization of services by the Medicare population, the numbers and types of providers needed to furnish these services, and geographic location of providers and enrollees. The analysis should include the following: The M+CO should have routine reporting and analysis reflecting the Medicare enrollees' utilization of their health delivery network in order to determine numbers and types of providers needed, practice patterns, rates of referrals, and the prevalence of certain conditions of their Medicare enrollees such as age, physical/mental disabilities, and language/cultural barriers. Review to determine if the M+CO has an internal process in place with appropriate staff (QA, UM, and provider relations) that routinely analyzes the availability and accessibility of their health care delivery network. Assess if the M+CO has ever developed internal corrective action plans when

	availability/accessibility problems have been identified. The M+CO must go beyond simple counts of providers or if providers are accepting new patients. The M+CO must have a process for measuring available full-time equivalents for individual providers or unused capacity for hospitals and other facilities.

MOE QH 01 cont.	■ The M+CO's provider network standards must address the following: Define the types of providers to be used when more than one type of provider can furnish a particular item or service. Identify the types of mental health and substance abuse providers in their network. Specify the types of providers who may serve as an enrollee's primary care physician (Cross Refer to Standard 3.1.1.1). Make specialists available to enrollees for services customarily furnished by specialists in the M+CO's area. The M+CO must ensure that providers are distributed so that no enrollee residing ~~is~~ in the service area must travel an unreasonable distance to obtain covered services. As a general rule, primary care, hospital care, and commonly used specialty and referral services must be available within 30 minutes driving time. Longer travel times are permissible based on location and established routine patterns of care such as rural areas. ■ The M+CO must also assess other means of transportation that the Medicare enrollees rely on such public transportation. The M+CO must ensure that sufficient providers to serve enrollees are available by way of public transportation. ~~**Note to reviewer:** If the M+CO has a "continuation area," the M+CO must provide "reasonable access" per 422.54(d)(2) through contracts with providers or direct payment of claims under rules provided in 422.54(d) and other operational policy as HCFA may communicate.~~

QH 02 ~~New Element~~	**The M+CO maintains and monitors a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services and to meet the needs of the population served. CFR 422.112 (a)(1),QISMC requirement 3.1.1** **[ ]MET [ ] NOT MET [ ]** **NOTE**
MOE QH 02	NOTE: Ultimately, it is the M+CO that must assess the needs of the populations it proposes to enroll and construct a network to meet those needs. Compliance with this standard will therefore focus on the M+CO's service planning and on the basic assumptions used by that M+CO in determining that its network is adequate to service the Medicare beneficiaries. **Review and/or Determine:** ■ The M+CO's network consists of employees and facilities of the M+CO, if any, along with providers who have entered into written agreements to serve the M+CO's enrollees. ■ ~~Review~~ written agreements with providers (contractors and subcontractors) to ensure compliance with OPL 98.077 and QISMC standards. ■ ~~Ensure that~~ all covered services are provided within the M+CO's provider network and located within the approved service area. Exception: M+COs operating in non-metropolitan areas may make a service (other than primary care and emergency care) available outside their approved area if it is unable to contract with sufficient numbers of providers within their approved area ~~if it is unable to contract with sufficient numbers within their approved area.~~ ■ ~~Review~~ HEDIS Practitioner Turnover measure (in context of overall marketplace) as part of review of provider network. NOTE: Infrequently used services may be made available through providers who have not entered into a formal written agreement with the M+CO. **Review and/or Determine:** ■ For any services furnished through non-contracting providers, ensure that the M+CO has procedures for identifying appropriate providers, referring

	enrollees to the providers as needed, and ensuring that the providers will accept payment from the organization as payment in full (subject to any allowable copayments or other cost sharing). ■ If an M+CO offers point-of-service benefits ensure that these benefits are available within the contracting network or through arrangements described above. No enrollee may be required to use the point-of-service benefit, or pay any extra charges imposed under the benefit, in order to obtain any medically necessary covered services.

QH 03 ~~New Element~~	**The M+CO offers a panel of primary care providers from which the enrollee may select a personal primary care provider.** **CFR 422.112 (a)(2), QISMC requirement 3.1.1.1** **[ ] Not Applicable [ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 03	**Review and/or Determine**: ■ The M+CO must provide a listing of current contracting primary care providers (and other providers that HCFA may designate) that specify: the location of the provider's practice site(s), ~~their non-English language capabilities, board and/or advanced practice certifications, whether the provider also practices as a specialist with the organization's network,~~ and designate if the providers practice is open or closed to new enrollees. Optional: their non English language capabilities, board and/or advanced practice certifications, whether the provider also practices as a specialist with the organization's network. Review the M+CO's policies and procedures to ensure that all the Medicare enrollees can select and/or change their primary care providers without interference from the M+CO. ■ If an organization wishes to limit enrollees choice of providers it must establish a panel of PCPs from which an enrollee may choose. . ■ The M+CO's procedures should include that the primary care provider (and other providers that HCFA may designate) list is updated regularly and make the information on the providers easily accessible to current and potential enrollees.
QH 04 ~~New Element~~ ~~Revised from 9/98 version of QISMC~~	**The M+CO provides or arranges for necessary specialty care, including women's health services. The M+CO allows women enrollees the option of direct access to women's health specialists within the network for women's routine and preventive health care services. ~~The M+CO allows women direct access to a women's health specialist (e.g., gynecologist, certified nurse midwife) within the network for women's routine and preventive health care services while the M+CO maintains a primary care provider or some other means for continuity of care.~~** **CFR 422.112 (a)(3),QISMC requirement 3.1.1.2** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 04	NOTE: When an M+CO permits women to choose a women's health specialist as a primary care provider this standard will not require any change in a M+CO's policies and procedures. M+COs that do not allow this option must provide women with both a primary care provider and direct access to women's health specialist.

	Review and/or Determine: ■ ~~Review~~ the M+CO's methodologies that project the amount and types of specialists necessary to serve its anticipated enrollees, clearly stating the approach for ensuring availability of appropriate specialists (either within its network or as an infrequently utilized service under 3.1.1). ■ ~~Ensure that~~ the M+CO provide women with direct access to a women's health specialist for routine and preventive health care services, which are defined as breast exams, mammograms, and pap smears. ~~Provision of "direct access" requires that the M+CO may not require the woman to obtain any referral, or prior authorization as a pre-condition to seeking or receiving care for routine or preventive services from a women's health specialist.~~ ~~NOTE: The provision of "direct access" also applies to influenza vaccine. Influenza and pneumococcal vaccines must be available without imposing any cost sharing. CFR 422.100 (h)(1)(2).~~
QH 05 ~~**New Element**~~ ~~**Revised**~~ ~~from 9/98 version of QISMC~~	**The M+CO has in effect procedures ~~approved by HCFA for~~: the identification of individuals with complex or serious medical conditions: and assessment of those conditions; the identification of medical procedures to address and/or monitor the conditions; and a treatment plan appropriate to those conditions that specifies an adequate number of direct access visits to specialists to accommodate implementation of the treatment plans that are time specific and updated. The organization must also have procedures for ensuring adequate coordination of care among providers. ~~Also, treatment plans are time-specific and updated periodically by the primary care or other appropriate provider or means.~~** **CFR 422.112 (a)(4), QISMC requirement 3.1.1.3** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 05	~~NOTE: These standards do not delineate criteria for identifying "individuals with complex or serious medical conditions." Because the manner in which such populations (e.g., children with special needs ESRD) are defined varies according to both the individual defining the population and the purpose for which the population is defined, these guidelines do not specify a definition of "individuals with complex or serious conditions."~~ ~~Review and/or Determine:~~ ~~■ The M+CO must develop in consultation with appropriate primary and specialty clinicians, operational definitions that the M+CO will implement within its network of providers to identify such individuals with complex or serious medical conditions.~~ ~~***NOTE: This standard does not require that an M+CO develop formal programs for every variety complex condition, but establish a formal process for responding to any complex need as it arises in its enrollee population.***~~ ~~■ Determine if the M+CO has a formal process that will identify the conditions for which more intensive care management is necessary and specify who in the M+CO will coordinate care for those particular enrollees.~~ ■ Review the M+CO's policies and procedures for the following: Policies and procedures were developed in consultation with appropriate health care professionals.

	The M+CO's policies and procedures encompass and ensure that all such individuals receive: (1) an assessment of all of their medical, psychological and social conditions, and (2) the medical care needed to fully address and monitor those conditions. Determine how the M+CO facilitates communication and information exchange among all treating health care professionals. When assessment needs are identified for medical, psychological, or social services that are outside the scope to the organization's Benefit package, the M+CO should have appropriate policies and procedures for making referrals to and coordinating care with appropriate external agencies and providers to be involved in the care of the enrollee. Request documentation to substantiate that the M+CO is making appropriate referrals based on care needs of the enrollee. ■ The M+CO must implement treatment plans consistent with the enrollee's coverage and address the needs identified by the assessment. The effective treatment must encompass the following: Individual goals for the patient. Identify needed resources. Periodically evaluate outcomes and needs for further intervention. Care that requires a specialist. The organization should provide direct access to the specialist in sufficient quantity consistent with the patient's treatment plan. The organization's care programs should identify conditions that are prevalent in its population and for which continuity and effectiveness of care would be improved through targeted programs. Communication and Information must be exchanged among professionals involved in the care of conditions requiring multiple sources of treatment or levels of care.
MOE QH 05 cont.	All treatment plans must be (1) developed by the primary care provider or another designated member of the interdisciplinary team responsible for the patient or by other means, (2) be established for a specific period of time, and (3) identify target dates for reassessment of progress toward and/or accomplishment of desired patient outcomes. Effective care coordination programs should (1) set individual treatment goals for each participant, (2) identify necessary resources, and (3) periodically evaluate outcomes and the need for further intervention. ~~■ The organization should have care coordination programs that include the following:~~ ~~Identify needed resources.~~ ~~Periodically evaluate outcomes and needs for further intervention.~~ ~~Care that requires a specialist, the M+CO should provide direct access visits to the specialist in sufficient quantity consistent with the~~ ~~All treatment plans must be (1) developed by the primary care provider or another designated member of the interdisciplinary team responsible for the patient or by other means, (2) be established for a specific period of time, and (3) identify target dates for reassessment of progress toward and/or~~

	~~accomplishment of desired patient outcomes.~~ ~~■ The M+CO should have care coordination programs that include the following:~~ ~~The M+CO's care programs should identify conditions that are prevalent in its population and for which continuity and effectiveness of care would be improved through targeted programs.~~ ~~Effective care coordination programs should (1) set individual treatment goals for each participant, (2) identify necessary resources, and (3) periodically evaluate outcomes and the need for further intervention.~~ ~~Communication and information must be exchanged among professionals involved in the care of conditions requiring multiple sources of treatment or levels of care.~~ ~~NOTE: This standard does not require that a M+CO develop formal programs for every variety of complex problem.~~
QH 06 **~~Revised~~** ~~from 9/98 version of QISMC~~	**An M+CO makes a good faith effort to ~~inform beneficiaries~~ provide written notice of the termination of a contracted provider within at least 30 calendar days ~~within a reasonable time~~ before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating irrespective or whether the termination was for cause or without cause. ~~Notice is sent to all enrollees who are seen on a regular basis by the provider whose contract is terminating.~~ For all terminated or terminating primary care providers, all enrollees are notified. 422.111(e) ~~and 422.204(c)(4)~~, QISMC requirement 3.1.1.4** **[ ] Not Applicable [ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 06	~~NOTE: The M+CO has a responsibility to ensure continuity of care to the enrollee in the event that there is potential interruption through changes in assigned care givers. This does not mean that the beneficiary has the right to continue to see a terminated specialist while remaining enrolled in the M+CO. If the beneficiary chooses to remain enrolled in the M+CO, the M+CO is only obligated to ensure that care from a comparable specialist or primary care provider is made available. M+COs are not required to send beneficiaries notices when contract negotiations with providers go past the termination date and a contract extension is implemented during the negotiation period. However, the contract extension must include language calling for a 60 day notice period before the negotiations actually cease and the contract is finally terminated, in order to ensure an opportunity for advance notice to the enrollee.~~ **Review policies to determine the following:** Notifies the enrollees in a timely fashion of ~~the involuntary~~ any termination which does not interfere with planned clinic visits or provision of care. The notice should be in compliance with CFR 422.111(e), (~~15 working days~~ 30 calendar days). ~~Also, the notice should explain the process for the beneficiary to return to original Medicare.~~
QH 07	**When medically necessary, the M+CO makes services available 24 hours a day, 7 days a week. 422.112(a)(8),QISMC requirement 3.1.3** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 07	**Review and/or Determine:**

	■ Medicare law requires that the M+CO must ensure the availability of essential health care providers during normal business hours and at a minimum, telephone contact/triage services by health care professionals outside of business hours. **Review for the following:** Provider contract language addressing the requirement for 24 hour coverage of care. The provider manual should have a policy and procedure that outlines the M+CO's requirements for the provider that ensures 24 hour coverage of care. The M+CO should conduct periodic audits on their contracting providers outside normal business hours to determine if their after normal hours systems are adequate and working correctly. Review the M+CO's complaint log for any complaints concerning enrollees not being able to access health care services after hours and determine if the M+CO took appropriate action. If the M+CO contracts with entities that provide after hours phone contact/triage services, determine if the M+CO's quality and medical utilization committees have approved the contracting entities' medical guidelines used for screening/triaging complaints. Also, has the M+CO reviewed the credentials and training of the health professionals handling the phone contact triage services. Determine if the M+CO's provider network has adequate provisions for referring patients in an expeditious fashion to a health care/emergency facility within reasonable distance from the enrollee.
QH 08	**The M+CO ensures that the hours of operation of its providers are convenient to and do not discriminate against enrollees. 422.112(a)(8), QISMC requirement 3.1.4** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 08	Review and/or Determine: ■ Provision of after hours service, particularly for urgent care, is essential if inappropriate utilization of emergency room services is to be avoided. Therefore, determine the M+CO's accessibility and capacity for: (1) access to care after normal working hours (5 p.m. to 9 a.m.) for those urgent medical events that require attention after hours; (2) the operating hours of provider sites for the provision of care to enrollees who are not able to take off from work to receive their care; (3) the hours of operation do not discriminate against Medicare enrollees relative to other enrollees.
QH 09 ~~New Element~~ ~~Revised~~	**The M+CO ensures that services are provided in a culturally competent manner to all enrollees, including: those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds. ~~the homeless, and individuals with physical and mental disabilities.~~ 422.112(a)(9),QISMC requirement 3.1.5** **[ ] MET [ ] NOT MET [ ] NOTE**

~~from 9/98 version of QISMC~~	

MOE QH 09	NOTE: For the purposes of QISMC, cultural competence within the health care delivery system refers to the development and provision of systems of care for culturally diverse populations. **Review and determine the following:** ■ That the M+CO's health care delivery system includes a demonstrated awareness and integration of health; its related benefits and cultural values; disease incidence and prevalence; and the appropriate management and prevention of disease as it relates to the presenting culture. ■ Strategies for cultural competence include as examples: the increased use of interpreters; incorporating in-house internship training programs; recruiting and retaining culturally diverse students and health professionals; and continuing educational programs for existing staff which result in increased knowledge, attitudes and skills which are culturally appropriate and, as a result, more clinically competent.
QH 10	**An established M+CO seeking an expansion of its service area demonstrates that the numbers and types of providers available to enrollees are sufficient to meet the projected needs of the population and area to be served. 422.112(a)(5), QISMC requirement 3.1.6** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 10	**Review and/or Determine:** ■ An M+CO seeking a service area expansion must substantiate the following: Identify the availability and accessibility standards that it will apply to the proposed service expansion area, if different from the standards adopted for the existing service area, the M+CO will document the basis for these standards, and demonstrate that its has sufficient network capacity to meet the standards. In addition, an M+CO that plans to furnish services through multiple formal sub-networks, as defined in the guidelines for standard 2.2.2, must ensure that each sub-network has adequate capacity to meet anticipated needs of the population it is projected to serve.
QH 11	**Standards for timeliness of access to care and member services that meet or exceed such standards as may be established by HCFA, continuously monitors its provider network's compliance with these standards, and takes corrective action as necessary. 422.112(a)(7)(I),QISMC requirement 3.1.7.1** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 11	NOTE: An M+CO is expected to ensure access and availability of services by developing its own standards and continuously monitoring its own compliance with these standards. Availability and accessibility standards must be performed separately for the Medicare population if provider networks are not identical. Standards. The M+CO must establish standards of timeliness of appointments and in-office waiting times for each type of service. The standards should consider the immediacy of member needs and common waiting times for comparable services in the community. An example of reasonable standards for primary care services might be: I Urgent but non-emergent – within 24 hours

	II Non-urgent but in need of attention – within one week III Routine and preventive – within 20 days Standards should include criteria for classification of complaints by level of urgency. Review and/or Determine: ■ What internal procedures are in place, whereby, the M+CO, as a routine function, continuously assesses access to all types of services (not just primary care) and modifies the network arrangements as necessary to correct any observed deficiency. ■ The M+CO must have standards for responsiveness of member services telephone lines. ■ How does the M+CO ensure that their affiliated providers are aware of the standards and are in compliance? ■ Determine if the M+CO has documentation that indicates that their primary care providers have appropriate backup for absences. ■ What internal tools does the M+CO utilize for monitoring compliance concerning access standards? Tools for monitoring may include: member surveys, analysis of member complaints and grievances, provider self reporting or audits, test calls, and the monitoring of phone abandonment rates (member services). ■ Corrective Action - ensure that the M+CO initiates corrective action on identified noncompliance with their standards and that the effectiveness of the corrective action is assessed.
QH 12	**Policies and procedures, including coverage rules, practice guidelines, payment policies and utilization management, that allow for individual medical necessity determinations. 422.112(a)(7)(ii), QISMC requirement 3.1.7.2** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 12	**Review and/or Determine:** ■ Review the following policy areas to ensure that utilization reviews, physician incentive plans, and preauthorization practices does not interfere with or cause delay in services or otherwise preclude delivery of health care providers. Utilization profiling/reporting on providers. Medical necessity and preauthorization procedures. Reimbursement mechanisms for contracting providers.
QH 13 ~~New Element~~	**The M+CO must develop a policy encouraging provider consideration of beneficiary input in the provider's proposed treatment plan. 422.112(a)(7)(iii), QISMC requirement 3.1.7.3** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 13	Determine and/or Review: ■ The M+CO's policies and procedures must contain language that ensures that enrollees are included in the planning and implementation of their care. ■ The M+CO's policies must include for the right of enrollees to be represented by parents, guardians, family members or other conservators for those who are unable to fully participate in their treatment decisions.

	■ ~~Review~~ the M+CO‘s physician provider manual and determine how the M+CO educates their contracting providers concerning the beneficiary‘s input for their proposed treatment plan. ■ The M+CO should communicate to their contracting providers that they are expected to: educate patients regarding their health needs, share findings of history and physical examinations, discuss potential treatment options (without regard to plan coverage), side effects of treatment, and management of symptoms; and recognize the patient has the final course of action among clinically acceptable choices.
	CONTINUITY AND COORDINATION OF CARE
QH 14 **~~Revised~~** ~~from 9/98 version of QISMC~~	**The M+CO~~ ensures continuity and coordination of care through~~ must ensure continuity of care and coordination of services through arrangements that include the offering of a health care professional who is formally designated as having primary responsibility for coordinating the enrollee‘~~s~~ overall health care or through other means. 422.112(b), QISMC requirement 3.2/3.2.1** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 15 **~~New Element~~**	**The M+CO‘s policies specify whether services are coordinated by the enrollees primary care provider or through some other means. OPL 98-72., QISMC requirement 3.2.1.1** **[ ] YES [ ] NO [ ] NOTE**
QH 16 **~~New Element~~**	**Regardless of the mechanism adopted for coordination of services, the M+CO ensures that each enrollee has an ongoing source of primary care. OPL 98-72, QISMC requirement 3.2.1.2** **[ ] YES [ ] NO [ ] NOTE**
MOE QH 14-16	**Review and /or Determine** The M+CO‘s policies and procedures should reflect their organizational structure by distinguishing among the following three different activities and how these activities will ensure continuity and coordination of care: ■ Delivery of primary care There must be an establishment of an ongoing relationship with the enrollee‘s usual source of primary care, if the enrollee desires and selects one. ■ Coordination of services. A health care professional, who may either be the primary care provider, a team of providers (for Medicare), or a plan employee who is a health care professional should have primary responsibility for evaluating the enrollee‘s needs, recommending and arranging the services required by the enrollee, and facilitating communication and information exchange among the different providers treating the enrollee. ■ Authorization of services. Many M+COs have a two-step process for determining whether non-urgent, non-primary care services will be

MOE QH 14-16 Cont.	provided or paid for: (a) the service must be recommended by the primary care provider or service coordinator, and (b) the service must be approved through a utilization management system. However, Medicare enrollees have a right to request any covered service, whether or not the service has been recommended by the health professional responsible for coordinating their care. It is therefore important to distinguish between the coordination function described in this standard and the approval function described in standard 3.3, even if a single health professional may sometimes play a role in both functions. ■ Policies and procedures should specify established mechanisms for coordinating different types of care services such as complex needs, chronic illnesses, functional disabilities and mental health. ■ Specific to mental health services, policies must ensure adequate coordination between the mental health and medical providers, for example with respect to prescribed medications. ■ The M+CO's policies must specify who may serve as the primary care provider and have procedures for evaluating a request by an enrollee (or by a practitioner on the enrollee's behalf) to use a non-primary care specialist as a principal source of primary care. ■ An M+CO may permit licensed practitioners other than physicians to serve as primary care providers, consistent with State laws. If an organization designates non physician practitioners as primary care providers, the enrollee must still have direct access to a physician upon request not subject to the non-physician's discretion. ■ A physician group, clinic, federally qualified health center, or other facility multiple practitioners may serve as a primary source of care. To the extent possible, the enrollee must be allowed to select an individual primary care provider within the group.
QH 17 ~~New Element~~	**The M+CO must ensure that programs for coordination of care that include coordination of services with community and social services are generally available through contracting or noncontracting providers in the area served by the M+CO. 422.112(b)(3), QISMC requirement 3.2.2** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 17	**Review and/or Determine:** ■ The M+CO's program and or policies ~~for policies~~ for ~~assuring~~ ensuring coordination among medical, mental health, ~~and~~ substance abuse services, and available social services or other community supports.
QH 18 ~~New Element~~	**The M+CO ~~organization~~ must ensure continuity and coordination of care through procedures for timely communication of clinical information among providers, as specified in QISMC standard 3.6. 422.112(b)(4), QISMC requirement 3.2.3** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 19 ~~New Element~~	**The M+CO ~~organization~~ ensures continuity and coordination of care through measures to ensure that enrollees: are informed of specific health care needs that require follow-up; receive, as appropriate, training in self-care and other measures they may take to promote their own health; and comply with prescribed treatments or regimens. 422.112(b)(5)&(6), QISMC requirement 3.2.4** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 19	**Review and/or Determine**

	■ The M+CO's policies and procedures for assuring that enrollees receive information they need to fully participant in their own care. The policies and procedures should include the following subject information: Self-care Medication management Use of medical equipment Potential complications and when these should be reported to providers Scheduling of follow-up services Patient education as part of discharge planning ■ The policies must include making counseling and facilitating services available for enrollees who are unable to, or are failing to, cooperate in their own treatment. These services should identify social, financial, or other barriers that are preventing enrollees from cooperating with treatment and referring to the appropriate social services.

	SERVICE AUTHORIZATION
QH 20 ~~**New Element**~~	**The M+CO ~~implements~~ establishes a formal mechanism ~~written policies and procedures~~, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. 422.202(b), QISMC requirement 3.3.1** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 21	**Criteria for decisions on coverage and medical necessity are clearly documented, are based on reasonable medical evidence or a consensus of relevant health care professionals, and are regularly updated. 422.202(b)(1), QISMC requirement 3.3.1.2** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 22	**Mechanisms are in place to ensure consistent application of review criteria and compatible decisions.** **OPL 98-72, QISMC requirement 3.3.1.3** **[ ] YES [ ] NO [ ] NOTE**
QH 23	**A clinical peer reviews decisions to deny authorization are determined on grounds of medical appropriateness.** **OPL 98-72, QISMC requirement 3.3.1.4** **[ ] YES [ ] NO [ ] NOTE**
QH 24	**The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services if the enrollee objects. The notice specifies the criteria used in denying or limiting authorization and includes information on how to request reconsideration of the decision pursuant to the procedures established under standard 2.4.3. The notice to the enrollee must be in writing.** **OPL 98-72, ~~42CFR422.80(c)(1);(iii)~~422.568© (c) ~~&(e);~~QISMC 2.4.1.3, QISMC requirement 3.3.1.5** **Cross reference to AP04/ Enrollee Rights** **[ ] YES [ ] NO [ ] NOTE**
QH 25 ~~**New**~~	**Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services.**

~~**Element**~~	**OPL 98-72, QISMC requirement 3.3.1.6** **[ ] YES [ ] NO [ ] NOTE**
QH 26 ~~**New Element**~~	**The M+CO does not prohibit providers from advocating on behalf of enrollees within the utilization management process. 422.206(a)(1), QISMC requirement 3.3.1.7** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 27 ~~**New Element**~~	**Mechanisms are in effect to detect both underutilization and over utilization of services.** **OPL 98-72, QISMC requirement 3.3.1.8** **[ ] YES [ ] NO [ ] NOTE**

MOE QH 20-27	~~NOTE: Standard 3.3.1.1 does not set a different maximum time frame for determinations, but requires each M+CO to establish its own time frames for responding to authorization requests and to monitor their compliance with the time frames.~~ **Review and/or Determine:** ■ Policy time frames may vary according to the urgency and complexity that is required so long as they do not exceed applicable legal limits. The M+CO should demonstrate their criteria for assigning levels of urgency and complexity. ■ Review provider manuals and policies to determine that the M+CO informs providers of the required information to process an authorization request and circumstances when additional information may be required. ■ Required information to make authorization determinations must in fact be needed only for the evaluation of the issue at hand and submission of medical records may not be routinely required. ■ Clinical criteria for review of authorization requests can be developed by the M+CO or by outside sources. However, clinical criteria must be approved and periodically reviewed based on scientific advances or changes in customary practice. The approval and periodic review should be performed by relevant health care professionals and the M+COs internal quality and utilization programs. ■ Clinical criteria for specific procedures must be made available upon request by an enrollee or affiliated provider. ■ ~~Determine~~ how the M+CO ensures that all employed and contracted reviewers understand coverage policies and review criteria for the authorization process. ■ ~~Ensure that~~ the M+CO periodically reviews their authorization decisions for consistency. ■ ~~Review~~ the M+CO's policies for medical necessity review and the procedure for denial of an authorization on grounds of medical appropriateness. ■ Does M+CO use the HEDIS measures in the Use of Services Domain to evaluate over and under utilization? ■ ~~Ensure~~ that denials of authorization due to medical necessity are made by a clinical peer. ■ The M+CO must have procedures clarifying when the reviewing clinician must or can obtain specialty consultations. Cross refer to element pertaining to QISMC standard 2.4.3 and the review of M+CO s Medicare Appeals procedures and Incentive Arrangements.

MOE QH 20-27 Cont.	■ ~~Ensure that~~ the M+CO's policies compensate individual reviewers and utilization review M+COs on the basis of time and/or numbers of authorization requests processed. No bonus or other incentive based on denials of medically necessary services are allowed. Compensation to persons or organizations conducting utilization management activities may not be structured to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services. ■ ~~Review~~ any capitation situations to physician groups that provide all ambulatory care and have an internal authorization system for specialty referrals to ensure Medicare standards are met. ■ ~~Review~~ provider contracts and M+CO policies to ensure there is no prohibition for a provider to assist an enrollee in obtaining authorization for a service or pursuing reconsideration requests. (Coordinate with Administration and Management review of contracts). Ensure the M+CO has developed policies, procedures, and has the reporting capabilities to detect both underutilization and over utilization of services. Determine if and how the M+CO's medical department carries out regular reviews of claims, the payment system, encounter data and medical record review to assess the degree of over and under utilization of health services. **Review and/or Determine:** ~~Determine/Evaluate~~: (1) how benchmarks are established, (2) the quality and frequency of provider feedback information and (3) if the M+CO conducts follow-up analysis on identified over and under utilization. Assess the M+CO's MIS capabilities to generate comprehensive reports which captures diagnosis, site of care delivery, provider identification and other significant elements.
QH 28	**The M+CO furnishes information to all affiliated providers about enrollee benefits. 422.202(b)(2),QISMC requirement 3.3.2** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 28	**Review and/or Determine:** ■ ~~Review~~ how and the frequency affiliated providers are given information on enrollee benefits. ■ The information should include clear expectations of covered services, drug formularies, and coverage decisions with respect to specific procedures or services.
	PRACTICE GUIDELINES AND NEW TECHNOLOGY
QH 29 ~~New Element~~	**The M+CO adopts and disseminates practice guidelines. 422.202(b)(2), QISMC requirement 3.4.1** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 30 ~~New Element~~	**Practice guidelines are based on reasonable medical evidence or a consensus of physicians in the particular field, consider the needs of the enrolled population, are developed in consultation with physicians, and are reviewed and updated periodically. 422.202(b)(1), QISMC requirement 3.4.1.1** **[ ] MET [ ] NOT MET [ ] NOTE**

QH 31 ~~**New Element**~~	**Practice guidelines, including any admission, continued stay, and discharge criteria used by the M+CO, are communicated to all providers and enrollees when appropriate, and to individual enrollees when requested.** **OPL 98-72, QISMC requirement 3.4.1.2 43 CFR 422.202 (b)(2)** **[ ] ~~YES~~ MET [ ] ~~NO~~ NOT MET [ ] NOTE**
QH 32 ~~**New Element**~~	**Decisions with respect to utilization management, enrollee education, coverage of services, and other areas to which the practice guidelines are applicable are consistent with the guidelines. 422.202(b)(3), QISMC requirement 3.4.1.3** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 33 ~~**New Element**~~	**The M+CO implements written policies and procedures for evaluating new medical technologies and new uses of existing technologies.** **OPL 98-72, QISMC requirement 3.4.2** **[ ] YES [ ] NO [ ] NOTE**
QH 34 ~~**New Element**~~	**The evaluations take into account coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and federal and state Medicaid coverage decisions, as appropriate to the evaluation.** **OPL 98-72, QISMC requirement 3.4.2.1** **[ ] YES [ ] NO [ ] NOTE**
MOE QH 29-34	**Note:** A statement of clinical principles, rationales, and policies related to clinical performance measures used by the M+CO is a guideline. **Review and/or Determine**: ■ ~~Review~~ the M+CO's internal mechanism and policies for adoption of practice guidelines. ■ Determine if the process for adoption of practice guidelines is separate from the QAPI program, if so, then the process should interface with the QAPI program. ■ Each M+CO also must include new practice guidelines based on the needs of their population or identified variations in practice patterns within the M+CO. ■ Practice guidelines must be evidence-based such as; Agency for Health Care Policy and Research, National Institutes of Health consensus panels, or by medical specialty societies. If these guidelines are not utilized, review the M+CO's process for developing new guidelines targeted to their own needs. ■ Verify that the M+CO has a formal mechanism for consulting affiliated physicians as guidelines are adopted and for reevaluating guidelines on a periodic basis. ■ Determine how the M+CO disseminates practice guidelines to physicians and selected relevant guidelines to the enrollees such as preventive and self care. Review provider manuals and newsletters. ■ Assess how the M+CO ensures that practice guidelines are consistent with utilization review criteria, coverage determinations, and any relevant QAPI projects. **NOTE:** New technologies include clinical interventions, procedures, pharmacological treatment, and devices.

MOE QH 29-34 Cont.	**Review and/or Determine:** ■ Ensure that the M+CO's internal mechanism and policies for evaluating existing and new medical technology meets the following criteria: An identifiable official or unit responsible for evaluation of such technologies. Procedures for specifying criteria for evaluation, collection of scientific evidence, review of findings by the Food and Drug Administration, and other regulatory bodies. ■ Conducts consultation with affiliated physicians and outside experts; and communication of coverage decisions to providers. ■ Determine if the M+CO is aware that they may not adopt coverage policies that are inconsistent with National Medicare coverage determinations. ■ Assess if the M+CO utilizes their local Carrier Advisory Committee as a resource for Medicare coverage issues.

	PROVIDER QUALIFICATIONS AND SELECTION
QH 35	**The M+CO implements a documented process for selection and retention of affiliated providers. 422.204(a),422.112(a)(6), QISMC requirement 3.5** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 36 ~~Revised from 9/98 version of QISMC~~	**The M+CO establishes procedures for initial credentialing, including: a written application, verification of licensure and other information from primary sources, disciplinary status, eligibility for payment under Medicare and Medicaid, and site visits as appropriate. The application is signed, dated and includes an attestation by the applicant of the correctness and completeness of the application. ~~422.204(a)(2)(I)~~ 422.204(b), QISMC requirement 3.5.1.1** ~~Change is in the guideline not the actual standard.~~ **[ ] MET [ ] NOT MET [ ] NOTE**
QH 37	**The M+CO establishes and maintains policies and procedures for recredentialing physicians and other health care professionals, at intervals required by HCFA ~~least every two years~~, through a process that updates information obtained in initial credentialing and considers performance indicators such as those collected through the QAPI program, the utilization management system, the grievance system, enrollee satisfaction surveys, and other activities of the M+CO. 422.204~~(a)~~ (b)(2)(ii), QISMC requirement 3.5.1.2** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 38 ~~New Element~~	**The M+CO must establish a process for receiving advice from contracting health care professionals with respect to criteria for credentialing and recredentialing of individual health care professionals. 422.204~~(a)~~ (b)(2)(iii), QISMC requirement 3.5.1.3** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 39 ~~New Element~~ ~~Revised~~	**The M+CO establishes written policies and procedures for suspending or terminating affiliation with a contracting physician~~,~~ including an appeals process. 422.204~~(c)(1)~~, 422.202(d), QISMC requirement 3.5.1.4**

~~from 9/98 version of QISMC~~	**[ ] MET [ ] NOT MET [ ] NOTE**
QH 40 ~~New Element~~	**The M+CO establishes formal selection and retention criteria that do not discriminate against health care professionals who serve high-risk populations or who specialize in the treatment of costly conditions.** **OPL 98-72, QISMC requirement 3.5.1.5** **[ ] YES [ ] NO [ ] NOTE**
QH 41 ~~New Element~~	**For each institutional provider or supplier, the M+CO determines, and redetermines at specified intervals, that the provider or supplier is licensed to operate in the state, and is in compliance with any other applicable state or federal requirements.422.204(a)(1)~~(I)~~(i), QISMC requirement 3.5.2.1** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 42 ~~New Element~~	**For each provider or supplier, the M+CO determines, and redetermines at specified intervals, that the provider or supplier is reviewed and approved by an appropriate accrediting body or is determined by the M+CO to meet standards established by the M+CO itself. ~~422.204 (a)(2),~~ 422.204(b)(2) QISMC requirement 3.5.2.2** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 43	**In the case of a provider or supplier providing services to Medicare enrollees, the provider or supplier is approved for participation in Medicare. (~~Note: This requirement does not apply to providers of additional or supplemental services for which Medicare has no approval standards.) 422.752.(a)(8),~~ 422.204(b)(3) QISMC requirement 3.5.2.3** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 44	**The M+CO notifies licensing and/or disciplinary bodies or other appropriate authorities when a health care professional's or institutional provider or supplier's affiliation is suspended or terminated because of quality deficiencies. ~~422.204 (c)(3),~~ QISMC requirement 3.5.3** **[ ] YES [ ] NO ~~[ ] MET [ ] NOT MET~~ [ ] NOTE**
QH 45	**The M+CO ensures compliance with Federal requirements prohibiting employment or contracts with individuals excluded from participation under either Medicare or Medicaid. ~~422.752.(a)(8),~~ 422.204(b)(3)QISMC requirement 3.5.4** **[ ] MET [ ] NOT MET [ ] NOTE**

MOE QH 35-45	(**Note to QH43:** This requirement does not apply to providers of additional or supplemental services for which Medicare has no approval/certification standards.) **Review and/or Determine:** ■ Credentialing policies and procedures must be approved by the policy making body or body designated by the policy-making body. ■ Process of provider selection should be integrated under Standard 3.1 (maintaining an adequate network - QH01). ■ The credentialing process must include the following: procedures for initial credentialing, written application, verification of licensure and other information from primary sources, disciplinary status, eligibility for payment under Medicare/Medicaid, and site visits as

MOE QH 35-45 Cont.	appropriate. ■ Credentialing applications must be signed, dated, and have applicant attestation to the correctness and completeness of the information provided. ■ The Credentialing process must be completed prior to appointment or contract affiliation. The information on the credentialing application and the signature must be no more than 6 months old on the date on which the provider is determined eligible for appointment or contract. ■ Review application regarding: a work history covering at least 5 years, any limitations in ability to perform the functions of the position, with or without accommodation. The history should check felony convictions, loss of privileges, and any disciplinary actions. ■ ~~The following must be verified from primary sources and included in the credentialing record:~~ ■ An M+CO must verify the following from primary sources and include in the credentialing records: Current valid license Clinical privileges in good standing with hospitals Valid DEA or CDS certificates Education, training and residency or special training Board Certification, if provider ~~states~~ claims Current and adequate malpractice insurance History of professional liability claims Information from the National Data Bank Information about sanctions or limitations on licensure by State or other Boards Information on previous sanction activity by Medicare/Medicaid ■ Review HEDIS measure Board Certification/Residency Completion contained in the Health Plan Description Domain. **Note:** Board certification is not a regulatory requirement for inclusion in the provider network.
	■ ~~Ensure that the M+CO maintains credentialing records which are current and up to date including; verification of licensure and other information from primary sources, as appropriate (for example: if a physician is credentialed in January of 2,000 and the site review takes place November of 2001, all information in the credentialing files must be current at the time of site review. If during the time period after initial credentialing and prior to the recredentialing process, licensure and other relevant information is scheduled to expire, it is the responsibility of the M+CO to ensure that all necessary licenses and certifications remain active.)~~ ■ Review the M+CO's procedure for site visits. Ensure that their procedure assesses accessibility, appearance, and adequacy of equipment, using standards developed by the M+CO. This may include site visits to high volume providers. Site visits should also include reviewing medical record keeping practices (Standard 3.6.2) and confidentiality requirements (Standard 2.2.1). ■ The M+CO's recredentialing must be at ~~least every two years~~ intervals required by HCFA and consider information from their QAPI program, utilization management, grievances and member satisfaction surveys. ■ Recredentialing must reverify from primary sources: licensure, clinical privileges, and malpractice coverage. Board certification for

providers due for recertification or for new states that they have become certified in.

- For recredentialing the National Data Bank must be re-queried. Also ~~and~~ obtain information from licensing agencies, Medicare, and Medicaid.
- The M+CO must have corrective action procedures for providers that have been sanctioned or disciplined that includes assessment of effectiveness.
- Review the M+CO's required credentialing mechanism/committee to determine that clinical peers develop and adopt credentialing standards~~, as well as, making~~ and make recommendations regarding provider participation.
- The M+CO must have a formal appeals process for physicians that are being terminated or suspended. The M+CO must notify all their affiliated physicians of their rules and provide for an appeals mechanism for terminated physicians including an opportunity for physicians to present information and their views on an adverse decision.
- Review the M+CO's selection and retention criteria to determine that there is no discrimination against health care professionals that serve high-risk populations or treat costly conditions.
- Review the M+CO's policies for credentialing and recredentialing institutional providers and suppliers. Ensure that the policies address all the criteria detailed in Standards 3.5.2, .3.5.2.1 (QH41), and 3.5.2.2 (QH42).
- Determine what mechanism the M+CO has in place to notify the appropriate State and Federal regulatory bodies and accrediting organizations upon suspending or terminating a provider because of quality deficiencies (QH44).
- The M+CO must have procedures in place that routinely ~~identifies~~ identify providers who opt out of Medicare for two years and that calls for review of the HCFA Sanction list.

ENROLLEE HEALTH RECORDS AND COMMUNICATION OF CLINICAL INFORMATION

QH 46 ~~**New Element**~~

The M+CO implements appropriate policies and procedures to ensure that the M+CO and its providers have the information required for effective and continuous patient care and for quality review, and conducts an ongoing program to monitor compliance with those policies and procedures. OPL 98-72, QISMC requirement 3.6

[ ] YES [ ] NO [ ] NOTE

QH 47 ~~New Element~~

~~Revised from 9/98 version~~

The M+CO ~~organizations~~ makes a "best-effort" attempt to conduct an initial assessment of each enrollee's health care needs, including following up on unsuccessful attempts to contact the enrollee, within 90 days of the effective date of enrollment. 422.112~~~~(a)(1)(v)(A)~~~~(b)(4)(i), QISMC requirement -3.6.1

[ ] MET [ ] NOT MET [ ] NOTE

~~of QISMC~~	
QH 48	**The M+CO ensures that each provider furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the M+CO that takes into account professional standards. 422.112(b)(4)(ii), QISMC requirement 3.6.2** **[ ] MET [ ] NOT MET [ ] NOTE**
QH 49 ~~New Element~~	**The M+CO enforces standards for health record content and organization, including specifications of basic information to be included in each health record. OPL 98-72, QISMC requirement 3.6.2.1** **[ ] YES [ ] NO [ ] NOTE**

QH 50 ~~New Element~~	**The M+CO implements a process to assess and improve the content, legibility, organization, and completeness of enrollee health records. OPL 98-72, QISMC requirement 3.6.2.2** **[ ] YES [ ] NO [ ] NOTE**
MOE QH 46-50	**Review and/or Determine** ■ ~~Review~~ policies and procedures to ensure that the M+CO and their providers collect relevant information for the delivery of effective and continuous patient care and for quality review. The M+CO must also have an ongoing program to monitor compliance with these policies and procedures. ■ ~~Determine~~ how the M+CO complies with the "best-effort" attempt to conduct an initial assessment within 90 days of enrollment. A physical exam is not required. The assessment may take the form of a phone call, home visit, or questionnaire. The 90-day assessment is not required for age-in and new enrollees under the care of network providers. ■ ~~Ensure that~~ the M+CO's policies for health record content include the following criteria: 1. Identifying information of the enrollee; 2. Identification of all providers participating in the enrollee's care and information on services furnished by these providers; 3. A problem list, including significant illnesses and medical and psychological conditions; 4. Presenting complaints, diagnoses, and treatment plans; 5. Prescribed medications, including dosages and dates of initial or refill prescriptions; 6. Information on allergies and adverse reactions (or a notation that the patient has no known allergies or history of adverse reactions); 7. Information on advance directives; 8. Past medical history, physical examinations, treatment necessary, and possible risk factors for the enrollee relevant to the particular treatment; ■ ~~Review~~ the M+CO's monitoring procedure for assessing content, legibility, organization and completeness of the enrollee's records. The monitoring procedures should include site reviews as specified in the MOE for Standard 3.5.

	Standard 3.6. The monitoring review should also include an assessment concerning confidentiality of medical and health information, as required under Standard 2.2.1.1

QH 51 ~~New Element~~	**Enrollee health records are available and accessible to the M+CO and to appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating enrollee grievances or complaints.** **OPL 98-72, QISMC requirement 3.6.2.3** **[ ] YES [ ] NO [ ] NOTE**
MOE QH 51	**Review and/or Determine** ■ Contracts with providers must specify that records will be made available to government reviewers, peer review organizations, external quality review organizations, or other authorized entities. (Coordinate with contract review in Administration and Management)
QH 52	**The M+CO ensures appropriate and confidential exchange of information among providers. 422.118, QISMC requirement 3.6.3** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 52	**Review and/or Determine:** ■ The requirements in this standard must be included in all provider agreements. Review of compliance should occur as part of reviews of record keeping practices under standard 3.6.2.2.
QH 53	**The M+CO maintains policies and procedures requiring that a provider making a referral transmits necessary information to the provider receiving the referral.** **OPL 98-72, QISMC requirement 3.6.3.1** **[ ] YES [ ] NO [ ] NOTE**
QH 54 ~~New Element~~	**The M+CO maintains policies and procedures requiring that a provider furnishing a referral service reports the appropriate information to the referring provider.** **OPL 98-72, QISMC requirement 3.6.3.2** **[ ] YES [ ] NO [ ] NOTE**
QH 55	**The M+CO maintains policies and procedures that requires providers to request information from other treating providers as necessary to provide care.** **OPL 98-72, QISMC requirement 3.6.3.3** **[ ] YES [ ] NO [ ] NOTE**
MOE QH 53-55	**Review and/or Determine:** ■ ~~Review~~ the M+CO's referral policies and procedures and assess how their affiliated providers are informed of these procedures. ■ M+COs that offer point-of-service benefits, should emphasize in their enrollee educational materials the importance of informing their primary care providers about the services they obtain.

	■ Some identifiable personal information can be released between Medicare and Medicaid managed care providers to the extent allowed under Federal and State laws. (Dually Eligibles)
QH 56 ~~**New Element**~~	**If the M+CO offers a point-of-service benefit or other benefit providing coverage of services by network or non-network providers, the M+CO transmits information about services used by an enrollee under the benefit to the enrollee's primary care provider, if one has been selected by the enrollee.** **OPL 98-72, QISMC requirement 3.6.3.4** **[ ] YES [ ] NO [ ] NOTE**
MOE QH 56	~~**Review and/or Determine:**~~ ■ Review policies and procedures. Cross refer to compliance with Standard 3.6.3.3.
QH 57 ~~**New Element**~~	**When an enrollee chooses a new primary care provider within the network, the enrollee's records are transferred to the new provider in a timely manner that ensures continuity of care.** **OPL 98-72, QISMC requirement 3.6.3.5** **[ ] YES [ ] NO [ ] NOTE**
MOE QH 57	■ Review policies and procedures.
QH 58	**The M+CO has policies and procedures for sharing enrollee information with any other M+CO or provider with which the enrollee may subsequently enroll or from whom the enrollee may seek care. 422.118~~(c)~~, QISMC requirement 3.6.4** **[ ] MET [ ] NOT MET [ ] NOTE**
MOE QH 58	**Review and/or Determine:** ■ The M+CO's policies and procedures must comply with the following: An enrollee's right to access their own medical record in accordance with State law. Authorization forms and policies must be in place which will safeguard the privacy of the patient record in transit. Requested information must be delivered in a timely manner as to not impede continuity of care.